CALIFORNIA CABG OUTCOMES REPORTING PROGRAM (CCORP)
CLINICAL ADVISORY PANEL (CAP)
Sutter Square Galleria
2901 K Street, Room 200 AB
Sacramento, CA 95816

July 20, 2007
9:30 a.m.

MEETING MINUTES

In Attendance

Clinical Advisory Panel Members:
Robert Brook, M.D., Sc.D.
Andrew Bindman, M.D.
Ralph Brindis, M.D., F.A.C.C.
Timothy Denton, M.D., F.A.C.C.
Coyness Ennix, Jr., M.D.
Keith Flachsbart, M.D.
Frederick Grover, M.D.

OSHPD:
David Carlisle, M.D.
Beth Wied, Chief Counsel
Beth Herse, Staff Counsel
Patrick Sullivan
Joseph Parker, Ph.D.
Holly Hoegh, Ph.D.
Denise King
Niya Fong
Victor Muh
Julie West
Pierre Washington

Other Attendees:
Ezra Amsterdam, M.D., UC Davis
Patrick Romano, UC Davis
Zhongmin Li, Ph.D., Health Services Researcher, UC Davis
Geeta Mahendra, Senior Analyst, UC Davis
Beate Danielsen, Ph.D, Analytic Consultant, UC Davis

Introduction

Dr. Robert Brook, Chairman, called the meeting to order at 9:30 and introductions took place. There were no members of the public in attendance.

Dr. David Carlisle thanked the CAP for its contributions to the 2003-2004 Coronary Artery Bypass Grafting (CABG) report. He discussed the media attention and mentioned that reception to the report was generally positive.

Dr. Brindis asked Dr. Carlisle to comment on the timeliness and delay of the release of the report. Dr. Carlisle discussed the review and evaluation process that the report went

through. He thought that this report was especially well scrutinized because it was a new subject and report for this Administration, and because of the sensitivity, since individual physicians were names. Dr. Carlisle did not feel that future reports will see that level of evaluation.

Dr. Brindis made a motion to approve the minutes by of the March 6, 2007 meeting. Dr. Bindman seconded and all approved.

Program Director's Report

Dr. Parker discussed the release of the new report. At the time of the meeting, there were 21 news paper reports as well as two radio interviews. Most of the articles had a focus on the local community, the surgeons and hospitals that were better than or worse than expected and the impact of that on the local community. Other themes included: the issues of surgeons avoiding high-risk patient and whether the risk model provides adequate adjustment for severely ill patients.

Dr. Brook commented that some of the quotes sounded like Dr. Parker did not believe in the report. Dr. Bindman felt that the coverage did not adequately note the state-of-the-art risk model and the input that created neutral ground for these issues. He commented that OSHPD should improve the public relations front end by speaking to the quality of the science related to the report.

Dr. Flachsbart asked if it was necessary to include the worse than and better than classifications for each surgeon in the report. Legal counsel noted that the law specifically states that OSHPD will report the groupings.

Dr. Brook continued with some observations about the media release: OSHPD should get the word out to hospitals that were close to being labeled that this is an opportunity for them to improve, OSHPD should improve the press release, and OSHPD should make the report more consumer-friendly. Dr. Brook also noted that the Press Release did not mention the results on Internal Mammary Artery usage. Dr. Brook cited a report on the outcomes of cystic fibrosis as a positive example and recommended distributing it to the panel members.

There was discussion about the release of future reports and to what extent the Panel should be involved in the preparation.

Dr. Parker reviewed the March 2007 CAP meeting accomplishments and outlined today's meeting. CCORP is working on a surgeon handbook and an on pump-off pump analysis that will be presented at the next meeting. Dr. Parker also mentioned that Dr. Richard Kravitz's appropriateness of revascularization proposal was included in the packets. Next, Dr. Parker presented the 2006 CABG surgery complication statistics with deaths excluded.

Dr. Parker discussed the appointment procedures for the Clinical Advisory Panel members. He cited the law and noted that it is the Office Director, Dr. Carlisle, who appoints the Clinical Panel. Members are appointed from a list of names submitted by, 1) the California Chapter of the American College of Cardiology, 2) the California Medical Association and 3) by consumer organizations. The term is for life, until resignation, or until the Director decides to rescind an appointment.

Next, Dr. Parker discussed the 45% decline in isolated CABG surgeries from 2000 to 2006. Dr. Flachsbart noted the number of PCIs have not changed much from 2003 to 2006, meaning California is doing less interventions overall. Dr. Parker mentioned that the number of hospitals that do less than 100 cases per year has also increased. Discussion followed about the issues involved with transparency when volume decreases.

Dr. Parker revisited the CAP decision to exclude salvage cases for surgeon outcome reporting that was made at the March 2007 meeting. Dr. Parker discussed the issues of timing and excluding salvage cases from the hospital level reports as well and recommended that the exclusion begin with 2007 cases. There was discussion of the issues. Dr. Brook asked for a vote and all were in favor of moving forward with the OSHPD recommendation that salvage cases be excluded from the surgeon level reports in 2007. OSHPD also recommended that salvage cases be excluded from hospital level reports. Further discussion included issues of transparency, surgeons refusing high risk patients, and gaming the system to look better. Dr. Brook asked for a vote and all but one member were in favor of the OSHPD recommendation to exclude salvage cases from both hospital and surgeon level reports.

Dr. Parker discussed the timeline for the 2005 hospital level report. He presented a review of the audit process and results for 2005 data. There was discussion of the hepatic failure coding difficulties, current training of the hospital coders and surgeons and efforts that could be taken to improve coding by the hospitals.

Dr. Parker presented the 2005 risk model. Dr. Brook asked for a vote to approve the model and all were in favor. A preliminary report will be created using this model and distributed to hospitals for the mandatory 60-day review. It was recommended that the report include a risk-adjusted mortality rate trend line and IMA usage trend line for 2003–2005.

Discussion of Proposed New Data Elements

Dr. Amsterdam presented the recommendations of the UC Davis consulting team for adding new data elements.

To enhance the isolated CABG Risk Model, the Team recommended adding albumin level (to replace hepatic failure) and socio-economic status elements such as zip code, address, education and/or insurance status. Zip code and insurance status would be available from the administrative data.

To develop a new risk model for Non Isolated CABG, the UC Davis Team recommended adding: previous valve surgery, type of valve or valves operated on, whether the valve disease was due endocarditis, and pulmonary artery mean pressure. These are all STS elements.

To develop a risk model for post-op stroke the UC Davis Team recommended adding: Prior or current atrial fibrillation/flutter, Post op atrial fibrillation, CPB perfusion time, Postop systolic BP <85mm >1 hr (Yes/No), Aortic crossclamp, Aortic crossclamp time.

To develop a risk model for post-op renal failure the UC Davis Team recommended adding: CPB Perfusion time, Postop systolic <85mm >1 hr, Post op use of blood products, Aortic crossclamp, Aortic crossclamp time, Pre op use of ACE inhibitor, Use of aprotinin, Intra-aortic balloon pump.

The UC Davis Team recommended adding the following NQF-endorsed process measures for public reporting: Pre-op beta blocker, Anti-platelet medication on discharge, and Beta blocker on discharge.

To assess CABG appropriateness the UC Davis Team recommended adding: Proximal left anterior descending (PLAD) artery bypassed (Yes/No; % Stenosis), Left circumflex artery bypassed (Yes/No; % Stenosis), and Right coronary artery bypassed (Yes/No; % Stenosis).

Discussion followed and the panel approved the collection of the following STS elements: previous valve surgery (Yes/No); Endocarditis (Yes/No); pulmonary artery mean pressure (mmHg); and Valve type(s) (aortic, mitral, tricuspid, pulmonic). Non-STS or modified-STS data elements approved for collection were: atrial fib/flutter; CVD type; and "was the LAD bypassed?"

The panel recommended that Dr. Carlisle communicate back to the Executive Branch that the law be changed to allow for greater flexibility in picking valid measures of appropriateness and process

Dr. Romano's Report on the Impact of Public Reporting

Dr. Romano presented his report on the impact of public reporting using California CABG Mortality Reporting Program **(**CCMRP) data.
There were significant increases in market share for low mortality outlier hospitals (persisting at 3, 6, and 12 months after publication). There was no significant trend for high mortality outliers or non-participating hospitals and no significant changes in observed mortality.
They were no significant changes in risk adjusted mortality during the study time period. Dr. Romano reported that expected mortality increased overall (at both CCMRP participants and non-participants), but not at low-mortality outlier hospitals. In addition, there was a significant increase in the statewide proportion of patients with PDD risk factors.

The panel proceeded to discuss the impact of the results through patient referrals to hospitals as well as promotional activities and their usefulness for hospitals. It was noted that the literature suggests that the report was used more by "CEOs who are worried about their names being in the newspaper".

The following factors significantly increased in reporting based upon OSHPD's Patient Discharge Data: COPD, cardiogenic shock, CHF, acute renal failure, and chronic renal failure. The following factors increased in reporting based upon CCMRP data: NYHA Class IV, ejection faction, and prior on-pump surgery. Dr. Romano found no evidence that high mortality outliers avoid high risk patients although there was some evidence that low mortality outliers avoid higher risk patients and operate on patients with an overall lower risk profile.

Dr. Parker closed the meeting with a discussion of the timeline for upcoming reports and OSHPD plans for a larger audit that will include all potential hospital and surgeon outliers for the next audit.

Dr. Brook adjourned the meeting at 1:44 PM.